

		FOR OHF USE					

LL1

2003  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2003)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042069

Facility Name: Alden of Old Town East

Address: 108 S. First Street      Bloomingdale      60108-2120  
Number      City      Zip Code

County: DuPage

Telephone Number: (630)671-1703      Fax # ( 630 )671-1706

IDPA ID Number: 36-3966584

Date of Initial License for Current Owners: 05/09/98

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:  
Name: Steven M. Kroll      Telephone Number: ( 773 )286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or  
Administrator  
of Provider

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_  
(Type or Print Name) Steven M. Kroll  
(Title) Chief Financial Officer

Paid  
Preparer

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_  
(Print Name and Title) \_\_\_\_\_  
(Firm Name & Address) \_\_\_\_\_  
(Telephone) ( )      Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE  
ILLINOIS DEPARTMENT OF PUBLIC AID  
201 S. Grand Avenue East  
Springfield, IL 62763-0001      Phone # (217) 782-1630

Facility Name & ID Number Alden of Old Town East

# 0042069 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,357	355		5,712	13
14	TOTALS	5,357	355		5,712	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.81%

D. How many bed-hold days during this year were paid by Public Aid?  
82 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 07/06/98

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 07/06/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/03 Ending: 12/31/03

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	45,257	2,813		48,070		48,070		48,070			1
2	Food Purchase		26,058		26,058	(2,260)	23,798	6,034	29,832			2
3	Housekeeping	1,474	6,901		8,375	307	8,682		8,682			3
4	Laundry		563		563		563		563			4
5	Heat and Other Utilities			17,238	17,238		17,238	360	17,598			5
6	Maintenance	2,223		22,735	24,958		24,958	807	25,765			6
7	Other (specify):*			127	127		127		127			7
8	<b>TOTAL General Services</b>	48,954	36,335	40,100	125,389	(1,953)	123,436	7,201	130,637			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	310,964	16,081	570	327,615		327,615	(485)	327,130			10
10a	Therapy											10a
11	Activities		2,336	23,039	25,375		25,375		25,375			11
12	Social Services	30,657			30,657		30,657		30,657			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	341,621	18,417	27,609	387,647		387,647	(485)	387,162			16
	<b>C. General Administration</b>											
17	Administrative	23,374			23,374		23,374		23,374			17
18	Directors Fees											18
19	Professional Services			85,562	85,562		85,562	(74,220)	11,342			19
20	Dues, Fees, Subscriptions & Promotions			3,032	3,032		3,032	(2,066)	966			20
21	Clerical & General Office Expenses	25,351	3,060	13,409	41,820		41,820	(165)	41,655			21
22	Employee Benefits & Payroll Taxes			49,253	49,253	1,953	51,206	5,555	56,761			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,563	2,563		2,563	1,209	3,772			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,327	10,327		10,327	2,343	12,670			26
27	Other (specify):* <b>bad debt</b>			1,333	1,333		1,333	(1,333)				27
28	<b>TOTAL General Administration</b>	48,725	3,060	165,479	217,264	1,953	219,217	(68,677)	150,540			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	439,300	57,812	233,188	730,300		730,300	(61,961)	668,339			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,320	4,320		4,320	41,758	46,078			30
31	Amortization of Pre-Op. & Org.							626	626			31
32	Interest			122,460	122,460		122,460	(9,631)	112,829			32
33	Real Estate Taxes							14,319	14,319			33
34	Rent-Facility & Grounds			110,863	110,863		110,863	(110,863)				34
35	Rent-Equipment & Vehicles			5,512	5,512		5,512	2,229	7,741			35
36	Other (specify):*							7,238	7,238			36
37	TOTAL Ownership			243,155	243,155		243,155	(54,324)	188,831			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,034	4,340	5,374		5,374	(1,323)	4,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,513	65,513		65,513		65,513			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,034	69,853	70,887		70,887	(1,323)	69,564			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	439,300	58,846	546,196	1,044,342		1,044,342	(117,608)	926,734			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(161)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,550)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(271)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(308)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,333)	27		24
25	Fund Raising, Advertising and Promotional	(1,589)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,222)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(5,615)	Various	34
35	Other- Attach Schedule	(104,771)	PG 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (110,386)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (117,608)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	
			Reference	
1	late fees on utilities	\$ (283)	6	1
2	intercompany interest	(106,011)	32	2
3	Misc income w/g service fee	(23)	21	3
4				4
5	back out 30.13% of IHCA dues	(261)	20	5
6	back out prior year vend settlement credit	121	6	6
7	Adj depree exp to correct detail amount	856	30	7
8	back out prior year vend settlement credit	121	21	8
9	recl vend settlement credit	(121)	6	9
10	Credit rent expense	830	34	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(104,771)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/03 Ending: 12/31/03  
 SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(161)	0	0	6,195	0	0	0	0	0	0	0	6,034	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	360	0	0	0	0	0	0	0	0	360	5
6	Maintenance	(283)	0	1,170	0	0	0	(24)	(56)	0	0	0	807	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(444)	0	1,530	6,195	0	0	(24)	(56)	0	0	0	7,201	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(360)	(125)	0	0	0	0	0	0	(485)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	(360)	(125)	0	0	0	0	0	0	(485)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(308)	3,092	(77,004)	0	0	0	0	0	0	0	0	(74,220)	19
20	Fees, Subscriptions & Promotions	(2,121)	0	55	0	0	0	0	0	0	0	0	(2,066)	20
21	Clerical & General Office Expenses	(3,452)	0	3,211	46	30	0	0	0	0	0	0	(165)	21
22	Employee Benefits & Payroll Taxes	0	0	5,548	0	7	0	0	0	0	0	0	5,555	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,209	0	0	0	0	0	0	0	0	1,209	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,315	28	0	0	0	0	0	0	0	0	2,343	26
27	Other (specify):*	(1,333)	0	0	0	0	0	0	0	0	0	0	(1,333)	27
28	TOTAL General Administration	(7,214)	5,407	(66,953)	46	37	0	0	0	0	0	0	(68,677)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,658)	5,407	(65,423)	5,881	(88)	0	(24)	(56)	0	0	0	(61,961)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	856	28,497	10,584	0	1,821	0	0	0	0	0	0	41,758    30
31	Amortization of Pre-Op. & Org.	0	462	163	0	0	1	0	0	0	0	0	626    31
32	Interest	(106,021)	91,581	4,805	0	3	1	0	0	0	0	0	(9,631)    32
33	Real Estate Taxes	0	13,643	675	0	1	0	0	0	0	0	0	14,319    33
34	Rent-Facility & Grounds	830	(111,693)	0	0	0	0	0	0	0	0	0	(110,863)    34
35	Rent-Equipment & Vehicles	0	0	2,229	0	0	0	0	0	0	0	0	2,229    35
36	Other (specify):*	0	7,238	0	0	0	0	0	0	0	0	0	7,238    36
37	TOTAL Ownership	(104,335)	29,728	18,456	0	1,825	2	0	0	0	0	0	(54,324)    37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0    38
39	Ancillary Service Centers	0	0	0	0	(4)	(1,319)	0	0	0	0	0	(1,323)    39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0    40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0    41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0    42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0    43
44	TOTAL Special Cost Centers	0	0	0	0	(4)	(1,319)	0	0	0	0	0	(1,323)    44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(111,993)	35,135	(46,967)	5,881	1,733	(1,317)	(24)	(56)	0	0	0	(117,608)    45



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See Page 6K		See Page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent revenue	\$ 111,693	Alden of Bloomingdale Limited Partnership		\$	(111,693)	1
2	V	32	Revenue from investments	16,609	Alden of Bloomingdale Limited Partnership			(16,609)	2
3	V	19	Audit		Alden of Bloomingdale Limited Partnership		1,267	1,267	3
4	V	19	Misc. Admin Expense		Alden of Bloomingdale Limited Partnership		1,825	1,825	4
5	V	33	Real estate taxes		Alden of Bloomingdale Limited Partnership		13,643	13,643	5
6	V	26	Insurance expense		Alden of Bloomingdale Limited Partnership		2,315	2,315	6
7	V	32	Interest on Loans - Prudential		Alden of Bloomingdale Limited Partnership		30,671	30,671	7
8	V	32	Interest on operating loss loan		Alden of Bloomingdale Limited Partnership		23,003	23,003	8
9	V	36	Mortgage insurnace premuim		Alden of Bloomingdale Limited Partnership		7,238	7,238	9
10	V	30	Depreciation		Alden of Bloomingdale Limited Partnership		28,497	28,497	10
11	V	31	Amortization		Alden of Bloomingdale Limited Partnership		462	462	11
12	V	32	Interest on mortgage		Alden of Bloomingdale Limited Partnership		20,404	20,404	12
13	V	32	Prepayment charged on debt				34,112	34,112	13
14	Total			\$ 128,302			\$ 163,437	\$ * 35,135	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	employee benefits	\$	Alden Management Services,Inc.		\$ 5,548	\$ 5,548	15
16	V	19	professional services	78,603	Alden Management Services,Inc.		1,599	(77,004)	16
17	V	21	general and admnistrative		Alden Management Services,Inc.		3,211	3,211	17
18	V	5	utilities		Alden Management Services,Inc.		360	360	18
19	V	6	repairs and maintenance		Alden Management Services,Inc.		1,170	1,170	19
20	V	24	auto/travel		Alden Management Services,Inc.		1,209	1,209	20
21	V	26	insurance		Alden Management Services,Inc.		28	28	21
22	V	20	dues/subscriptions		Alden Management Services,Inc.		55	55	22
23	V	30	depreciation		Alden Management Services,Inc.		10,584	10,584	23
24	V	31	amortization		Alden Management Services,Inc.		163	163	24
25	V	33	real estate taxes		Alden Management Services,Inc.		675	675	25
26	V				Alden Management Services,Inc.				26
27	V	35	rental equipment/auto		Alden Management Services,Inc.		2,229	2,229	27
28	V	32	interest		Alden Management Services,Inc.		4,805	4,805	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 78,603			\$ 31,636	\$ * (46,967)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube-feeding	\$	Pyramid Health Care		\$ 6,195	\$ 6,195	15
16	V	10	nursing supplies	360	Pyramid Health Care			(360)	16
17	V	39	per diems/other supplies		Pyramid Health Care				17
18	V	21	gen'l & admin		Pyramid Health Care		46	46	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 360			\$ 6,241	\$ * 5,881	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	\$ 25	Forum Extended Care II		\$ 21	\$ (4)	15
16	V	10	house stock	806	Forum Extended Care II		681	(125)	16
17	V	39	I.V.		Forum Extended Care II				17
18	V	22	emplouee benefits		Forum Extended Care II		7	7	18
19	V	21	gen'l& admin		Forum Extended Care II		30	30	19
20	V	32	interest		Forum Extended Care II		3	3	20
21	V	33	real estate tax		Forum Extended Care II		1	1	21
22	V	30	depreciation		Forum Extended Care II		1,821	1,821	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 831			\$ 2,564	\$ * 1,733	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	therapy	\$ 4,236	Community Physical Therapy		\$ 2,917	\$ (1,319)	15
16	V	32	interest		Community Physical Therapy		1	1	16
17	V	31	amortization		Community Physical Therapy		1	1	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,236			\$ 2,919	\$ * (1,317)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3	4	5	6	7	8	
Schedule V			Cost Per General Ledger		Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Line	Item	Amount	Name of Related Organization				
15	V	6	repairs and maintenance	\$ 7,610	Alden Bennett Construction		\$ 7,586	\$ (24)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 7,610			\$ 7,586	\$ * (24)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	CARPET CLEANING	\$	ALDEN REALTY - CARPET CARE		\$		15
16	V	6	FLOOR CLEANING	980	ALDEN REALTY - FLOOR CARE		924	(56)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 980			\$ 924	\$ * (56)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

ALDEN NURSING CENTER - EAST

# 42069

Report Period Beginning

01/01/03

Ending:

12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
ANC Waterford	Aurora
Alden of Old Town West	Bloomingtondale
Alden Trails	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governs Park	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living



VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A Schlossberg	President		100.00	344,680	0.216	0.54	Salary	\$ 1,872	17-1	1
2	Lauren Magnusson	Coordinator		A	86,595	0.216	0.54	Salary	470	10-1	2
3	Terry Magnusson	Maintenance Supr		A	83,739	0.216	0.54	Salary	455	6-1	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,797		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Prudential		X	Mortgage-refinanced/pd off	\$6,066.00	1997	\$ 873,700	\$	9/2037	7.9700	\$ 30,671	1	
2	Cambridge		X	operating loss loan	\$2,122.00	06/02	339,267	335,440	9/2037	6.8300	23,003	2	
3	Cambridge		X	Mortgage	\$4,506.00	09/03	873,700	871,679	8/2043	5.5000	20,405	3	
4	Prepayment charge on debt	X		Addition to the Old Loan							34,112	4	
5												5	
	Working Capital												
6	Related party - AMS	X									4,805	6	
7	Related party - FECII	X									3	7	
8	Related party - CPT	X									1	8	
9	TOTAL Facility Related				\$12,694.00		\$ 2,086,667	\$ 1,207,119			\$ 113,000	9	
	B. Non-Facility Related*												
10	Offset Interest expense with Bloom Assoc interest income										(161)	10	
11	Interest income on Corp										(10)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (171)	14	
15	TOTALS (line 9+line14)						\$ 2,086,667	\$ 1,207,119			\$ 112,829	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 7,238 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.  
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.  
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1998	9,337	8
1999	10,978	9
2000	11,120	10
2001	11,435	11
2002	12,559	12

Accrual based on 3% increase over prior year bill

Amount recorded as paid in 2003 represents 1/3 of all real estate tax parcels assessed to Bloomingdale Assoc entities. Old Town East \$12,558.57, Old Town West = \$13,303.92, Trails = \$13088.65

TOTAL = \$38951.14 1/3 of total = \$12,983.71

Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

\$	11,900	1
\$	12,559	2
\$	659	3
\$	12,984	4
\$		5
\$		6
\$	13,643	7

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, call 773-286-3883.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Alden of Old Town East

COUNTY

DuPage

FACILITY IDPH LICENSE NUMBER

42069

CONTACT PERSON REGARDING THIS REPORT

Steven M. Kroll

TELEPHONE

773-286-3883

FAX #:

773-286-3743

A. **Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the real estate tax cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	01-15-201-020	Nursing Home Facility	\$ 12,558.57	\$ 12,558.57
2.		Related Party - Alden Management	\$ 125,008.00	\$ 675.00
3.		Related Party - Forum	\$ 8,317.00	\$ 1.00
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 145,883.57	\$ 13,234.57

B. **Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,848 B. General Construction Type: Exterior brick veneer Frame wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO  
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:  
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	14,400	1995	\$ 150,868	1
2					2
3	TOTALS	14,400		\$ 150,868	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Related party-Forum			1978	\$15,909	\$	22	\$	\$	15,909	4
5	16		1997	1997	934,861	23,372	40	23,372		129,164	5
6											6
7											7
8											8
	Improvement Type**										
9	TV Modules			1999	1,775	355	5	355		1,597	9
10	Sprinkler system			2001	2,345	234	10	234		625	10
11	ABC-counter tops			2003	8,091	607	10	607		607	11
12	Bill's Auto& Truck			2003	817	817	1	817		817	12
13	ABC roof repair			2003	1,685	14	10	14		14	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 965,483	\$ 25,399		\$ 25,399		\$ 148,733	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		\$ 1,037,210	\$ 27,676		\$ 27,676	\$	\$ 201,555	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$180,844	\$14,300	\$14,300	\$		\$103,288	71
72	Current Year Purchases	6,384	952	952			952	72
73	Fully Depreciated Assets	40,851	1,098	1,098			40,851	73
74								74
75	TOTALS	\$228,079	\$16,350	\$16,350	\$		\$145,091	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	98-'03	\$11,860	\$2,052	\$2,052	\$	3	\$11,658	76
77										77
78										78
79										79
80	TOTALS			\$11,860	\$2,052	\$2,052	\$		\$11,658	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,428,017	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$46,078	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$46,078	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$358,304	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Related party - cost backed out
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease

9. Option to Buy:

☐ YES☒ NO

Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES☐ NO
16. Rental Amount for movable equipment: \$3,084Description:Copy machine lease and postage meter rental

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	patient transport		\$210.00	\$2,429	17
18					18
19	related party		185.75	2,229	19
20					20
21	TOTAL		\$395.75	\$4,658	21

10. Effective dates of current rental agreement:

Beginning01/1/98

Ending06/01/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$90,808
13.	/2005	\$90,808
14.	/2006	\$12,612

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nurses on site

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 1,871	\$		\$ 1,871	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,187			1,187	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			1,283			1,283	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See page 16A	# of prescripts				669		669	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See page 16a					(959)		(959)	13
14	TOTAL			\$		\$ 4,341	\$ (290)		\$ 4,051	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	275,922	275,922	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	920	5,865	6
7	Other Prepaid Expenses	973	2,235	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from 3rd parties	29,989	29,989	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 307,804	\$ 314,011	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		21,734	12
13	Land		143,489	13
14	Buildings, at Historical Cost		934,861	14
15	Leasehold Improvements, at Historical Cost	14,713	14,713	15
16	Equipment, at Historical Cost	25,137	102,019	16
17	Accumulated Depreciation (book methods)	(16,422)	(173,776)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 23,428	\$ 1,043,040	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 331,232	\$ 1,357,051	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 63,814	\$ 63,814	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,436	4,436	28
29	Short-Term Notes Payable		8,929	29
30	Accrued Salaries Payable	32,635	32,635	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	2,118	2,118	31
32	Accrued Real Estate Taxes(Sch.IX-B)		12,983	32
33	Accrued Interest Payable		5,923	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr.ins, exps, idpa, sales tax etc	9,473	9,473	36
37	due to affiliates	205,602	150,496	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 318,078	\$ 290,807	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	221,765	865,389	39
40	Mortgage Payable		332,801	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Owner advances		19,095	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 221,765	\$ 1,217,285	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 539,843	\$ 1,508,092	46
47	TOTAL EQUITY(page 18, line 24)	\$ (208,611)	\$ (151,041)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 331,232	\$ 1,357,051	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (316,690)	1
2	Restatements (describe):		2
3			3
4			4
5	rounding adjustment	(1)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (316,691)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	108,080	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 108,080	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (208,611)	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Alden of Old Town East # 0042069 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,112,480	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,112,480	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	w/g service fee	23	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,112,513	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	125,389	31
32	Health Care	387,647	32
33	General Administration	217,264	33
	B. Capital Expense		
34	Ownership	243,155	34
	C. Ancillary Expense		
35	Special Cost Centers	5,374	35
36	Provider Participation Fee	65,513	36
	D. Other Expenses (specify):		
37	Related party salaries allocations	(39,909)	37
38	not to be included on this page, but		38
39	included on page 3 and 4.		39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,004,433	40
41	Income before Income Taxes (line 30 minus line 40)**	108,080	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 108,080	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	650	693	\$ 20,953	\$ 30.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,732	2,813	73,500	26.13	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	750	790	7,811	9.89	14
15	Cook Helpers/Assistants	3,320	3,583	36,902	10.30	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	95	95	662	6.97	18
19	Laundry					19
20	Administrator	641	671	15,773	23.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,640	1,980	30,657	15.48	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	22,038	23,145	213,133	9.21	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	31,866	33,770	\$ 399,391 *	\$ 11.83	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		4,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		384	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		21,777	11-3	44
45	Social Service Consultant		1,262	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,423		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53



XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
D. Moller	administrator	0	14,361	Workers' Compensation Insurance	\$	7,386	IDPH License Fee	\$			
				Unemployment Compensation Insurance		6,241	Advertising: Employee Recruitment		138		
				FICA Taxes		26,481	Health Care Worker Background Check				
				Employee Health Insurance		7,390	(Indicate # of checks performed 10 )		70		
Various executives	assit admin	0	9,013	Employee Meals		2,260					
				Illinois Municipal Retirement Fund (IMRF)*			IHCA dues		603		
				Life and dental insurance/Pension		554	Surety Bond Fees		100		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 23,374	401k match		141	Related Parties - Ams		55		
(List each licensed administrator separately.)				Employee vaccinations/drug test		654					
B. Administrative - Other				Employee Relations		100	Less: Public Relations Expense	(			
Description			Amount	Related parties - Ams		5,555	Non-allowable advertising	(			
			\$				Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	56,761	TOTAL (agree to Sch. V, line 20, col. 8)	\$	966		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
C. Professional Services				Description	Line #	Amount	Description		Amount		
Vendor/Payee	Type		Amount				Out-of-State Travel	\$			
AMS	Management Fees	\$	78,603								
BDO Seidman	Accounting Fees		3,400								
Kenneth Fish/Barry Greenburg	legal fees		2,977								
Neal Gerber & Eisenberg	legal fees		63				In-State Travel				
Janet hermann	Professional Fees		133				Auto and Gasoline		1,818		
Talx/NSN employer	Unemployment Consult		386								
							Related Parties-Ams		1,209		
							Seminar Expense				
							Ill Health Care Assoc (non recp/dinner)		100		
							Ill Health Care Assoc (convention/rgst))		645		
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 85,562	TOTAL			(agree to Sch. V, line 24, col. 8)				
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL		3,772		

\* Attach copy of IMRF notifications

\*\*See instructions.

**(See instructions.)**

[illegible]

Facility Name &amp; ID Number Alden of Old Town East

# 0042069

Report Period Beginning: 01/01/03

Ending: 12/31/03

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. Ill Healthcare Assoc.-\$864
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,566 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,513  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 2,249 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? n/a  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training?** yes  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: BDO Seidman, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not available yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Alden Nursing Center - Old Town East  
Reporting Period Beginning  
Reporting Period Ending

1/01/03  
12/31/03

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(2,260)	Employee Meal
	22	1,953	Employee Meal
	3	307	Uniforms
		<hr/> 0	Net should be 0